

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-4

CERTIFICATE OF DEATH

01070

Reg. Dist. No. 162

1. PLACE OF DEATH:

County GarettCity or town Grantsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County GarettCity or town Grantsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Christain C. Beachy

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Bertha Beachy

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

March 22-1871

8. AGE:

Years

76

Months

-

Days

II

If less than one day

_____ hrs.

_____ min.

8. Birthplace R.D.I. Accident Md

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Christain J Beachy13. Birthplace R.D.I. Accident Md14. Maiden name Mary Beeghley15. Birthplace R.D.I Accident Md16. Informant Fredrick BeachyAddress Oakland Md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4-5-1947

(month) (day) (year)

Cemetery or crematory GrantsvilleLocation Grantsville Md18. Funeral director Wm. WinterbergAddress Grantsville Md19. 47
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 7 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 1 1947 to Apr 2 1947
and that I last saw him alive on Apr 2 1947

Immediate cause of death

Chronic Myocarditis

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE W. B. Davis M.D.

M. D. or other

Address Grantsville Md Date signed 4/3/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

Reg. Diat. No. 01071
166

1. PLACE OF DEATH: County <u>Garrett</u> City or town <u>Mt. Lake Park</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>one month</u> Hospital, institution, or street address where death occurred: <u>Thayer Nursing Home</u> How long in hospital or institution? <u>one month</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>md</u> County <u>Garrett</u> City or town <u>Friendsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) if veteran, name war _____			
3. (a) FULL NAME <u>John Fredrick Bowman</u>				3. (b) Social Security Number <u>NONE</u>			
4. Sex <u>male</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>single</u>		MEDICAL CERTIFICATION 2D. DATE OF DEATH <u>4-12-47</u> 19____ at <u>4:30</u> M	
6. (b) Name of husband or wife _____				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>4-1-47</u> 19____ to <u>4-12-47</u> 19____ and that I last saw him <u>in</u> alive on <u>4-11-47</u> 19____			
7. Birth date of deceased (mo., day, yr.) <u>March 26, 1877</u>				6. (c) If alive, give age _____ years			
8. AGE: Years <u>70</u>		Months <u>—</u>		Days <u>16</u>		If less than one day _____ hrs. _____ min.	
9. Birthplace <u>Near Accident Md</u> (Town, county, and state)							
1D. Usual occupation <u>Laborer</u>							
11. Industry or business _____							
FATHER		12. Name <u>John W. Bowman</u>					
MOTHER		13. Birthplace <u>Accident Md.</u>					
		14. Maiden name <u>Louisa Thomas</u>					
		15. Birthplace <u>Markleysburg Penna.</u>					
16. Informant <u>Charles Bowman</u> Address <u>Friendsville Md.</u>							
17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Mar. 14, 1947</u> (month) (day) (year) Cemetery or crematory <u>Brotherly Cemetery</u> Location <u>Near Accident Md.</u>							
19. Funeral director <u>W. W. Savage</u> Address <u>Friendsville Md.</u>							
19. <u>3/13/77</u> <u>Julius G. Rowan</u> (Date rec'd by registrar) Registrar							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____							
23. SIGNATURE <u>Edward H. Thomas</u> <u>Edward H. Thomas</u> M. D. or other Address _____ Date signed <u>4-14-47</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

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APR 23 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

01072

Reg. Dist. No. 163

1. PLACE OF DEATH:

County Garrett
 City or town Bloomington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years 8 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Bloomington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Harry Thomas Broadwater

3.(b) Social Security Number

213-01-8870

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>	
6.(b) Name of husband or wife <u>Blanche Reeman</u> <u>Broadwater</u>			
6.(c) If alive, give age <u>30</u> years			
7. Birth date of deceased (mo., day, yr.) <u>July 20, 1914</u>			
8. AGE: Years <u>32</u>	Months <u>8</u>	Days <u>13</u>	If less than one day hrs. min.
9. Birthplace <u>near Bloomington, Garrett, Md.</u> (Town, county, and state)			
10. Usual occupation <u>Laborer</u>			
11. Industry or business <u>W. P. A.</u>			
MOTHER	12. Name <u>Ephrian Broadwater</u>		
	13. Birthplace <u>Maryland</u>		
	14. Maiden name <u>Ida Rounds</u>		
FATHER	15. Birthplace <u>Maryland</u>		

16. Informant _____
 Address _____

17. Burial Date thereof April 5, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Philos Cemetery
 Location Westernport, Maryland
Ellsworth S. Boal
 18. Funeral director Westernport, Maryland
 Address _____

19. 4-5 19 47 Dorey Pattison
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 47 at 7:30 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 41 to April 3 19 47
 and that I last saw him alive on April 3 19 47
 Immediate cause of death Congestive heart failure DURATION 2 mo
Valvular heart disease 8 yrs
Rheumatic fever 12 yrs
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings and operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James S. Harrison Jr MD M. D. or other
 Address Piedmont W. Va Date signed 4-5-47

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APR 8 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1173

CERTIFICATE OF DEATH

Reg. Dist. No. 01074
166

1. PLACE OF DEATH:

County GarrettCity or town near Deer Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town near Deer Park
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Henry William Deihl

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteSingle

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) December 4, 18688. AGE: Years Months Days If less than one day
79 4 12 _____ hrs. _____ min.9. Birthplace Frostburg, Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

FATHER 12. Name Edward Deihl
13. Birthplace GermanyMOTHER 14. Maiden name Catherine McMann
15. Birthplace Cumberland, Md.16. Informant Mrs. Fred HoltschneiderAddress Deer Park, Md.17. Burial Date thereof April 19, 1947
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Deer ParkLocation near Deer Park18. Funeral director Emory BoldenAddress Oakland Md19. 4/17/47 19. 47 Julius C. Rowan
(Date rec'd by registrar) (year) (Name) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 47 at 2:15 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 13, 19 47, to April 13, 19 47and that I last saw him alive on April 13, 1947 19 _____Immediate cause of death Hemorrhage

DURATION

Due to Gastric ulcers

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

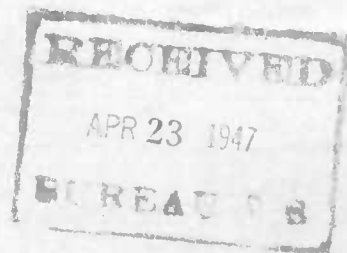
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE A.E. Hance M. D. or otherAddress Oakland, Md. Date signed 4/17/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 01075
166

1. PLACE OF DEATH:

County GarrettCity or town Oakland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Life

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Harry Oscar Durst

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Married

8.(b) Name of husband or wife Daisy Myrtle White Durst8.(c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) August 28, 18788. AGE: Years Months Days If less than one day
68 7 19 _____ hrs. _____ min.9. Birthplace New Germany, Garrett, Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name James Madison Durst13. Birthplace New Germany, Md.14. Maiden name Nancy Daniels15. Birthplace Cove, Maryland18. Informant Floyd DurstAddress Oakland, Md.17. Burial Date thereof April 19, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oakland CemeteryLocation Oakland, Md.18. Funeral director Emory D. BoldenAddress Oakland, Md.19. 4/18/47 47 Julius A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947 at _____21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 17, 1945, to April 17, 1947
and that I last saw him alive on April 17, 1947Immediate cause of death Coronary Occlusion

DURATION

Due to arterio sclerosis 10 yrs.Due to Hypertensive heart disease 10 yrs.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W.E. Pearce MD M. D. or otherAddress Oakland, Maryland Date signed April 18

1947

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APR 23 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

01076

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garett
 City or town R.D.I Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garett
 City or town R.D.I Grantsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Christain J. Folk

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Elizabeth Folk 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 17-1864
 8. AGE: Years 82 Months 8 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Springs - Somerset Co Pa
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name John Folk
 13. Birthplace Springs-Somerset Co Pa
 MOTHER 14. Maiden name Matilda Hershberger
 15. Birthplace Rural Near Salisbury Pa

16. Informant Scott DuckworthAddress R.D.I Grantsville Md17. Burial Date thereof 4-23-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AccidentLocation Accident Md18. Funeral director Wm. A. HershbergerAddress Grantsville Md19. April 22 47 E. H. Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 47, at 2:30 ^a21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 47 to Apr 20 19 47and that I last saw him alive on Apr 15 19 47Immediate cause of death Chronic Myocarditis DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. R. Davis M.D. M. D. or other _____Address Grantsville Md Date signed Apr 24

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 23 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01077

Reg. Diat. No. 161

1. PLACE OF DEATH: Germantown
 County Frederick
 City or town Friendsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? All his life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md County Barnett
 City or town Friendsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME Homer Friend

3. (b) Social Security Number _____

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, Married

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) April 23 - 1861 8. (c) If alive, give age _____ years

8. AGE: Years 85 Months 11 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace 777 d
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Friend13. Birthplace Friendsville Md14. Maiden name Sims15. Birthplace Maryland16. Informant Randal FriendAddress Highwood Pa17. Burial Date thereof Apr 26 - 1947
 (Burial, cremation, or other disposal) (month) (day) (year)Cemetery or crematory Family Burial on farmLocation near Friendsville Md18. Funeral director W. W. SavageAddress Friendsville Md19. April 19 1947 Kathryn Fike
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 18 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1947 to April 18 1947 and that I last saw him alive on Mar 18 1947

Immediate cause of death Acute Myocarditis DURATION 2 days

Note. This pt was found dead - probably due to natural causes - I never treated him for any condition while he lived
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Milton Tepper, M.D. M. D. or other

Address Friendsville Date signed April 19, 1947

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Date of death

3. Sex (Male or Female)

4. Age (Years and months)

5. Place of birth (City, State, and Country)

6. Usual residence (City, State, and Country)

7. Cause of death (State immediately preceding condition, if any)

8. Date of death

9. Signature of attending physician (Print name and sign)

10. Signature of registrar (Print name and sign)

11. Medical certification

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APR 28 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87c

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town McHenry, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town McHenry, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Archibald Glotfelty.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married.
 6.(b) Name of husband or wife Katie Glotfelty.
 6.(c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) May 4th, 1874
 8. AGE: Years 72 Months 11 Days 19 It less than one day hrs. min.

9. Birthplace McHenry, Maryland.
 (Town, county, and state)
 10. Usual occupation Retired Farmer
 11. Industry or business

12. Name Jess Glotfelty.
 13. Birthplace Salisbury, Pa.
 14. Maiden name Ester Warnick.
 15. Birthplace New Germany, Md.

16. Informant Mrs. Katie Glotfelty.
 Address McHenry, Maryland.

17. Burial Date thereof April 27/1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Flat Wood Cemetery.
 Location Near Accident, Maryland.

18. Funeral director Emory B. Bolden
 Address Oakland, Md.

19. 4/27/47 19 47 Julia Kanar
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.M

20. DATE OF DEATH April 23d. 19 47 at 9:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 31, 19 46 to Feb. 25, 19 47
 and that I last saw him alive on Feb. 25, 19 47

Immediate cause of death

DURATION

Due to Parkinson's Disease. 10 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Shaw M. D. or otherAddress Oakland, Maryland Date signed 4/25/47

STATE OF NEW YORK

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MAY 6 1947
BUREAU V S

JOSEPH P. MORAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01079

Reg. Dist. No. 172

1. PLACE OF DEATH:
County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60yrs.
Hospital, institution, or street address where death occurred:
W. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
Street No. W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ismena Maud Hamill

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Edward Jackson Hamill

7. Birth date of deceased (mo., day, yr.) June 21, 1871 8.(c) If alive, give age 81 years

8. AGE: Years 75 Months 9 Days 22 If less than one day
hrs. min.

9. Birthplace Terra Alta, W.Va.
(Town, county, and state)

10. Usual occupation Housework
Own Home

11. Industry or business

FATHER 12. Name Meshach Allan Browning
13. Birthplace W.Va.

MOTHER 14. Maiden name Molly Louise Holly
15. Birthplace W.Va.

16. Informant Miss Gladys Hamill
Kitzmiller, Md.
Address

17. Burial April 15, 1947
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Hamill Cemetery
Kitzmiller, Md.
Location

18. Funeral director Otha F. Sharpless
Kitzmiller, Md.
Address

19. April 15 19 47 W. B. Burdick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 47 at 1:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw her alive on April 13 19 47

Immediate cause of death Basal Ganglia -
neuron

Due to Cerebral Palsy
with inclusion of all the organs
Due to

Other conditions
(Include pregnancy within 3 months of death)

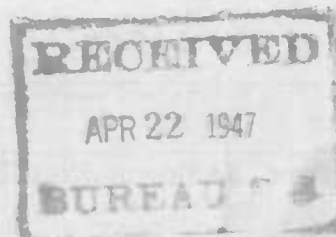
Major findings of operations Cerebral Palsy
signified with inclusion of all the organs
Date of op. Feb 25 1947

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ralph Colanbella M.D.
M. D. or other
Address Kitzmiller, Md. Date signed Apr 14 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
City or town Mt. Lake Park,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland, County Garrett
City or town Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

William H. Johnson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Unknown
7. Birth date of deceased (mo., day, yr.) February 21, 1862 8.(c) If alive, give age ----- years
8. AGE: Years 85 Months 2 Days -- If less than one day ----- hrs. ----- min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business General
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs. J. B. King
Address Mt. Lake Park, Md.

17. Burial April 22, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Wonderly Cemetery
Location 2 Mi., So. Mt. Lake Park, Md.

18. Funeral director Herbert C. Leighton
Address Oakland, Md.

19. 4/22/47 19. 47 Julia Roman
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947 at 6:40P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 19, 1947, to 19
and that I last saw him alive on 4/19 1947
Immediate cause of death Uremia

Other conditions -----
(Include pregnancy within 3 months of death)
Major findings of operations -----
Date of op. -----
Autopsy results -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ----- Date of -----
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury ----- Injured at work? -----

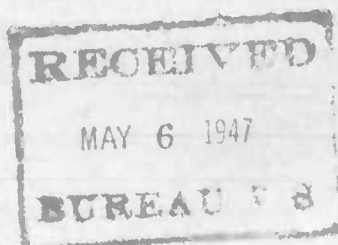
23. SIGNATURE Harold C. Miller M.D.
Address Egton, W. Va. Date signed 4/22/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

01080



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01081

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Deers Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? yr. 3 mos.
 Hospital, institution, or street address where death occurred:
12
 How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Deers Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

Frederick Daniel Kerns

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mary Josephine Clark7. Birth date of deceased (mo., day, yr.) Aug 28, 1866 8. (c) If alive, give age 1 years8. AGE: Years 80 Months 7 Days 12 If less than one day hrs. m/n.9. Birthplace Int. Savage Allegany Co. Md. (Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Kerns13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Carl HinchbaughAddress Deers Park, Md.17. Burial Burial Date thereof Apr. 13, 1947 (month) (day) (year)Cemetery or crematory Philos CemeteryLocation Westernport, Md.18. Funeral director M. E. EichhornAddress Lopacoring Md.19. 47 19 47 John G. Rowan Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 47 at 6 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 19 45 to Apr 10 19 47and that I last saw him alive on Apr 10 19 47Immediate cause of death Diabetic's ConvulsionDURATION 1 hourDue to Diabetes 4 yrsDue to High Blood pressure and 4 yrsValvular Heart Lesion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John G. Rowan M. D. or otherAddress Deers Park Md Date signed Apr 15, 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

See out of pocket. due to silencing

RECEIVED

APR 23 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH: Garnett
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....MD..... County.....Garnett
 City or town.....Friendville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
John Cabrera Lint
 4. Sex.....M..... 5. Color or race.....M..... 6. (a) Single, married, widowed, or divorced.....married

3. (b) Social Security Number

6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.).....June 28 1864..... 6. (c) If alive, give age..... years

8. AGE: Years.....83..... Months.....2..... Days.....10..... If less than one day..... hrs. min.

9. Birthplace.....Frazier Ridge Md
 (Town, county, and state)
Farmers

10. Usual occupation.....

11. Industry or business.....

12. Name.....Joseph E Lint13. Birthplace.....Md14. Maiden name.....Berntha J. Frazier15. Birthplace.....Md16. Informant.....Mrs Pearl ShultzAddress.....Addison Dr17. Burial Date thereof.....Apr 11 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Frazier RidgeLocation.....near Friendsville Md18. Funeral director.....M. M. SurgenAddress.....Friendsville Md19. April 12 1947 Kathryn Fike
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April - 8 - 1947 at.....9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April - 1 - 1947 to April - 8 - 1947
 and that I last saw him alive on April - 4 - 1947

Immediate cause of death.....Lobar Pneumonia..... DURATION.....7 days

Due to.....Influenza.....10 ..

Due to.....Senility - Mitral Stenosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....H. B. Messmore MDAddress.....Addison - P 9..... Date signed.....4/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF BALTIMORE

DEATH

RECEIVED

APR 18 1947

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 745

CERTIFICATE OF DEATH

01083

Reg. Dist. No. 161

1. PLACE OF DEATH: Garrette

County.....

City or town..... Friendsville R D
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Garrett.....

City or town..... Friendsville.....
(If outside city or town limits, write RURAL and give nearest town)Street No..... R. D.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

John T Loveridge

3. (b) Social Security Number

4. Sex.....

Male

5. Color or race.....

White

6. (a) Single, married, widowed, or divorced.....

Married

6. (b) Name of husband or wife..... Allie Fike

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Feb 17 1865

8. AGE: Years 82 Months 1 Days 25 If less than one day
hrs. min.9. Birthplace..... Wheeling W. Va.,
(Town, county, and state)
Farmer

10. Usual occupation.....

11. Industry or business..... On farm

12. Name..... Not Known

13. Birthplace..... Not Known

14. Maiden name..... Not Known

15. Birthplace..... Not Known

16. Informant..... Alie Loveridge

Address Friendsville R D,

17. Burial Date thereof Apr 15 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Asher Glade Cem-

Location.....

18. Funeral director..... E. G. Harned

Address Brandonville W. Va.,

19. April 14 1947 Kathryn Fike
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 12 47 9.A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Apr 4 - 19 47 to Apr 12 - 19 47
and that I last saw him alive on Apr 11 - 19 47

Immediate cause of death.....

Coronary Occlusion

Due to.....

Bronchial Asthma, Senility

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... H. B. Messmore

Address..... Addison Pa

Date signed 4-14-47

RECEIVED

APR 18 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Oakland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 monthsHospital, institution, or street address where death occurred:
Alder St.How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County GarrettCity or town Oakland
(If outside city or town limits, write RURAL and give nearest town)Street No. Alder St.
(If rural, give LOCATION)
-----2.(a) If veteran, name War -----

3. (a) FULL NAME

Paul Edward Martin

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Child6. (b) Name of husband or wife -----7. Birth date of deceased (mo., day, yr.) August 5, 19466. (c) If alive, give age ----- years8. AGE: Years --- Months 8 Days 5 If less than one day
----- hrs. ----- min.9. Birthplace Oakland, Md.
(Town, county, and state)10. Usual occupation -----11. Industry or business -----FATHER 12. Name Foster R. Martin13. Birthplace Preston Co., W. Va.MOTHER 14. Maiden name Elva E. Mills15. Birthplace Keyser, W. Va.16. Informant Foster R. MartinAddress Oakland, Md.17. Burial Date thereof April 12, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oakland CemeteryLocation Oakland, Md.18. Funeral director Herbert C. ReightonAddress Oakland, Maryland.19. 4/11/47 19. 47 Julius Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 19 47, at 6:10 P.M.21. I CERTIFY that death occurred on the date above signed; that I attended deceased from Examined after death 19 47and that I last saw him alive on ----- 19 47Immediate cause of death Broncho Pneumonia

DURATION

Due to InfluenzaDue to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

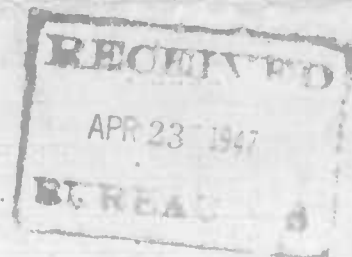
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Ed. Bannister, M.D. Seals rec'd.Address Oakland, Md. Date signed 4/11/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore ^{46-m}

CERTIFICATE OF DEATH

01085

Reg. Dist. No. 171

1. PLACE OF DEATH:

County Garrett
 City or town Accident RD#1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Accident Md. RD#1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Susan Schrock

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife xx Benjamin Schrock
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 25, 1874
 8. AGE: Years 72 Months 3 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Near Jennings (Garrett) Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Christian Orendorf
 13. Birthplace Near Jennings, Md.
 MOTHER 14. Maiden name Polly Hostetler
 15. Birthplace Not Known

16. Informant Noah Schrock
 Address Accident Md. RD#1

17. Burial Date thereof Apr. 20, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cherry Glade
 Location Near Bittering, Md.

18. Funeral director Wm Winterberg
 Address Grantsville, Md.

19. Apr. 19 19 47 J.B. Emery Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 47, at 1: P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 19 47 to present time 19 47
 and that I last saw him alive on Apr. 2 19 47

Immediate cause of death Underspread Cancer of all abdominal viscera.

Due to Cancer of abdominal viscera. Cause impossible to determine primary site.
 Due to Duration Undetermined.

Other conditions Ascites
 (Include pregnancy within 8 months of death)

Major findings of operations none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide no Date of —
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury none Injured at work?

23. SIGNATURE Charles W. Hottel, M.D.
 Address 344 Mass St. Maryland Date signed 18 Apr. 1947
 M. D. or other

RECEIVED

APR 22 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01086 166

1. PLACE OF DEATH:

County Garrett
City or town Mt. Lake Park,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
Kiser's Nursing home
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Rural Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 Mi. So. Mt. Lake Park, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

Hulda Jane Lower Sims

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
6. (b) Name of husband or wife <u>James H. Sims</u>			
7. Birth date of deceased (mo., day, yr.) <u>August 8, 1866</u>			
8. AGE: Years <u>80</u>	Months <u>8</u>	Days <u>16</u>	It less than one dayhrs.min.
9. Birthplace <u>Garrett Co., Md.</u> (Town, county, and state)			
10. Usual occupation <u>House Wife</u>			
11. Industry or business <u>Own Home</u>			
12. Name <u>Henry Lower</u>			
13. Birthplace <u>Garrett Co., Md.</u>			
14. Maiden name <u>Roxilena Lipscomb</u>			
15. Birthplace <u>Garrett Co., Md.</u>			

16. Informant <u>Josiah Sims</u> Address <u>Mt. Lake Park, Md.</u>	
17. Burial <u>April 26, 1947</u> (Burial, cremation, or removal. Which?) (month) (day) (year) <u>Pleasant Valley Cemetery</u> Cemetery or crematory <u>3 Mi. So. Oakland, Md.</u> Location <u>Herbert C. Leighton</u> 18. Funeral director <u>Oakland, Maryland.</u> Address <u>4/26/47</u> 19. (Date rec'd by registrar) <u>47</u> Registrar <u>Julia Rouse</u>	

MEDICAL CERTIFICATION

20. DATE OF DEATH <u>April 23,</u> <u>47</u> <u>7:45P.</u>	19 <u>46</u> <u>47</u>
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>November 10, 1946</u> to <u>April 23, 1947</u> and that I last saw him alive on <u>April 23, 1947</u>	
Immediate cause of death <u>M yocardial failure</u>	DURATION
Due to <u>arteriosclerosis</u>	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings of operations	Date of op.
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	

22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide	Date of
Where did injury occur? (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	Injured at work?
Means of injury	
23. SIGNATURE <u>Julia Rouse</u> M. D. or other <u>47</u>	
Address <u>Oakland, Md.</u> Date signed <u>4/26/47</u>	

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 6 1947

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01087

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Rural Deer Park,
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Rural Deer Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 3 Mi. N W. Deer Park
(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

Roberta Ruth Smith

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife -----

7. Birth date of deceased (mo., day, yr.) August 18, 19298. AGE: Years 17 Months 8 Days 2 It less than one day
.....hrs.min.9. Birthplace Garrett Co., Md.
(Town, county, and state)10. Usual occupation House work11. Industry or business at home12. Name Warden Smith13. Birthplace Fayette Co., Penna.14. Maiden name Mary Wonderly15. Birthplace Preston Co., W. Va.16. Informant Warden SmithAddress Deer Park, Md.17. Burial April 23, 1947

(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Ferndale CemeteryLocation 3 Mi. No. Oakland, Md.18. Funeral director Herbert C. LeightonAddress Oakland, Maryland.19. 4/23/47 Julia Rowan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 47 at 9:45A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19..... to19.....

and that I last saw h.....alive on19.....

Immediate cause of death
Self inflicted bullet wound in heart

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4-19-47Where did injury occur? In home
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Self inflicted Bullet wound

in heart

23. SIGNATURE Herbert C. Leighton M. D. or otherOakland, Maryland Date signed 4-23-47

Address.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 6 1947

BUREAU 7 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-2)

FILE No. G 110 JUN 23 1947 **CERTIFICATE OF DEATH**

Reg. Dist. No. 01088

1. PLACE OF DEATH:
 County... Garrett
 City or town... Near Deer Park, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
Life time
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Garrett
 City or town... Near Deer Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Richard Scott Tasker.

3. (b) Social Security Number
None

4. Sex Male **5. Color or race** White **6. (a) Single, married, widowed, or divorced** Widower

8. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.) April 2d, 1866 **8. (c) If alive, give age** years

8. AGE: Years 81 Months 7 Days 0 If less than one day hrs. min.

9. Birthplace West Va., Mineral County.
 (Town, county, and state)

10. Usual occupation Blacksmith.

11. Industry or business

12. Name Joseph Tasker

13. Birthplace West Va.

14. Maiden name Catherine Sharpless.

15. Birthplace West Va.

16. Informant Harper Paugh.

Address Deer Park, Md.

17. Burial Burial Date thereof April 13/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Paugh Cemetery

Location Near Deer Park, Md.

18. Funeral director Emory D. Golden

Address Oakland, Md.

19. (Date rec'd by registrar) 4/12/47 **Registrar** Julius G. Bowen

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 9¹⁵ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Spammed after death 19.....
 and that I last saw him alive on 19.....

Immediate cause of death Barbiturate Poisoning

Due to Alcoholism

Due to Intoxication from alcohol

not due to cancer, cancer

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Date of**

Where did injury occur?
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury **Injured at work?**

23. SIGNATURE D. J. Baumgartner M.D.

Address Oakland, Md. **M. D. or other**

Date signed 4/12/47

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

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APR 23 1947

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01089

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
25 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland. County Garrett
 City or town Mt. Lake Park,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -----
 (If rural, give LOCATION)

 2.(a) If veteran, name war -----

3. (a) FULL NAME

Grace Elda Fearer Turney

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Flaveus J. Turney
 B. (c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) November 11, 1881
 8. AGE: Years 65 Months 4 Days 25 If less than one day
 ----- hrs. ----- min.

9. Birthplace Preston Co., W. Va.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business Own Home
 12. Name Joseph Fearer
 13. Birthplace Preston Co., W. Va.
 14. Maiden name Amanda Vansickle
 15. Birthplace Preston Co., W. Va.

16. Informant Joseph Turney
 Address Mt. Lake Park, Md.
 17. Burial April 8, 1947
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Oakland Cemetery
 Location Oakland, Md.
 18. Funeral director Herbert C. Leighton
 Address Oakland, Maryland.
 19. 4/18/47 47 Julia G. Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 5 1947, to April 5 1947
 and that I last saw her alive on April 5 1947

Immediate cause of death

DURATION

Coronary Heart failure
 Due to arteriosclerosis
 Due to myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Gannon M. D. or otherAddress Oakland, Md. Date signed 4/7/47

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SURFACE 6

Evidence for the change of age
is shown on U 110 6/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

01690

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
City or town Oakland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Swanton
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)

2(a) If veteran, name war -----

3. (a) FULL NAME

Lawson Wright

3. (b) Social Security Number

215-16-4206

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Henrietta Friend

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 22, 1872

8. AGE: Years 74 Months 11 Days 17 If less than one day
----- hrs. ----- min.

9. Birthplace Garrett Co., Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

FATHER 12. Name William Wright

13. Birthplace Garrett Co., Md.

MOTHER 14. Maiden name Jane Harvey

15. Birthplace Garrett Co., Md.

16. Informant William Coddington

Address Oakland, Md.

17. Burial Date thereof April 9, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory George Cemetery

Location Swanton, Md.

18. Funeral director Herbert C. Leighton

Address Oakland, Maryland.

19. 4/9/47 19 47 Julius A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 19 47 AT 11:30A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 19 43 to 4-6-47 19

and that I last saw him alive on 3-31-47 19

Immediate cause of death Paralysis

1 week

Due to High Blood Pressure
and Chronic Nephritis

4 years

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

----- Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Edmund B. Brown M. D. or other

Address Oakland, Maryland Date signed 4-6-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 23 1947

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